MID-YEAR CHANGE FORM

INSTRUCTIONS & DEADLINE FOR ELECTIONS – Use this form to make mid-year changes to your State of Montana Benefit Plan (State Plan) coverage.

- This form and the appropriate verification of dependent eligibility or ineligibility documentation **must be postmarked or returned within 31 days of returning from a leave of absence, within 60 days of a Special Enrollment Period, or 91 days of the birth/adoption/placement of a child(ren) or anytime mid-year if an employee who previously waived State Plan coverage now needs to enroll in Core Benefits** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.
- In order to make a mid-year change to your State Plan coverage, you must qualify for a Special Enrollment Period as outlined in the Wrap Plan Document (WPD). A Special Enrollment Period is a period of time during which an eligible person may request to add or remove coverage under the State Plan as a result of certain events that create special enrollment rights. To view the full WPD, visit www.benefits.mt.gov/Publications.
- The effective date of the requested mid-year change will be determined by HCBD in accordance with the Wrap Plan Document. To view the full WPD, visit www.benefits.mt.gov/Publications.
- The Health Care & Benefits Division (HCBD) website, www.benefits.mt.gov, includes important benefit information to help you understand State Plan rates, coverages, and benefit options.

PERSONAL INFORMATION

EMPLOYEE/RETIREE ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

DATE OF BIRTH ____-____-_____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

CURRENT BENEFITS – For information about your current benefit coverage, contact HCBD at (800) 287-8266.

MID-YEAR EMPLOYEE CORE BENEFIT ENROLLMENT – Check this box if you would like to enroll in State Plan coverage mid-year, but you do not qualify for a Special Enrollment Period.

- ❑ If you check this box, you understand you are only eligible for Core Benefits and you do not qualify for benefits due to a Special Enrollment Period. Core Benefits include employee only medical, dental, and basic life.

WAIVER OF COVERAGE – Check this box if you would like to waive State Plan coverage.

- ❑ If you check this box, you and any covered spouse/domestic partner and/or dependent child(ren) will no longer be covered by the State Plan. A benefit eligible employee may re-enroll at any time, but your spouse/domestic partner and/or dependent child(ren) will not be able to come back to the State Plan until the next Open Enrollment Period or with a Special Enrollment Period as outlined in the Wrap Plan Document.

REINSTATEMENT OF COVERAGE DUE TO LEAVE OF ABSENCE (LOA)

Date Returned from LOA: _____

- ❑ Check this box if you would like to reinstate your State Plan Core Benefits. Core Benefits include employee only medical, dental, and basic life. Only Core Benefits can be reinstated for employees returning from leave for reasons other than Active Duty Military Leave or Family Medical Leave Act (FMLA).

- ❑ Check this box if you would like to reinstate your State Plan Optional Benefits. Only applies to employees returning from Active Duty Military Leave or FMLA. You will also need to complete the Coverage Election, Vision Hardware Coverage, Life Insurance and Flexible Spending Account sections of this form. (If making this election, form must be completed and returned within 31 days of returning to work from Active Duty Military Leave or FMLA.)
  If returning from Active Duty Military Leave indicate date coverage should be effective: _____

ADD A DEPENDENT (Dependent Verification of Eligibility Required for all Circumstances)

Date of Event: _____

- ❑ Marriage (including Common Law Marriage)
- ❑ Declaration of a Domestic Partner Relationship
- ❑ Birth/Adoption/Placement of Child
- ❑ Court-ordered Custody/Support/Legal Guardianship
- ❑ Dependent lost eligibility for other group medical coverage. Was coverage loss due to voluntary cancellation? ❑Yes ❑No
  (provide creditable coverage letter and proof of dependent eligibility—see back for details)
- ❑ Dependent transferring to you from another State Plan Member *(specify from whom)*
  Employee Name: _____ Employee ID# _____
- ❑ Elect Joint Core – Spouse/domestic partner is employed by the State of Montana and is benefit eligible and you have a dependent child(ren) on the State Plan. *(The member employed with the State of Montana the longest will be primary.)*
  Joint Core Partner's Name: _____ Employee ID# _____

VERIFICATION OF ELIGIBILITY - If you are adding a spouse/domestic partner and/or dependent child(ren), you are required to submit the verification of eligibility documentation as outlined below to HCBD with this form. You may submit this information via email to benefitsquestions@mt.gov with the subject line, "Mid-Year Change Dependent Verification." You can also mail it to HCBD, Attention: "Mid-Year Change Dependent Verification", PO Box 200130, Helena, MT 59620.

- Dependent Children
  - o A copy of your child's/children's birth certificate(s), adoption order, pre-adoption order; or
  - o A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

ACTION REQUIRED ON NEXT PAGE!

- 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.

TERMINATE A DEPENDENT (Dependent Verification of Ineligibility Required for all Circumstances)

Date of Event: _____

- ❑ Death of Spouse/Child *(attach copy of a certified death certificate)*
- ❑ Divorce/Legal Separation/Change in Support Order *(attach signed copy of court order)*
- ❑ Dissolution of Domestic Partnership *(attach Domestic Partner Dissolution Form)*
- ❑ Spouse/Child Eligible for Other Employer Group Health Plan Benefits (*attach documentation from plan/employer)*
- ❑ Loss of dependent eligibility status other than previously listed (due to, specify: _____) *(attach documentation)*
- ❑ Cancel Joint Core due to Spouse's Employment Termination or Childs(rens) Loss of Eligibility

  Joint Core Partner's Name: _____ Employee ID#_____

COVERAGE ELECTION

Delete From Plan	Add to Plan	Name	Coverage (Circle M for Medical and/or D for Dental)	Birthdate	Relationship	SSN
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			
			M D			

VISION HARDWARE COVERAGE –<u>All</u> dependents enrolled on your Medical Plan will be enrolled on Vision Hardware Coverage if Vision Hardware Coverage has been elected for the Plan Year.

REINSTATEMENT OF COVERAGE ONLY: If returning from Active Duty Military Leave or FMLA, please complete:

❑ Yes, I want to enroll. ❑ No, I do not want to enroll.

LIFE INSURANCE – Put an x in the box of the option you would like to elect. Please keep in mind if you receive a salary increase it could increase the minimum amount of Life coverage you are required to elect.

Coverage	Elect Coverage	Cancel Coverage	Add or Change* – New Total Amount:
***Employee Supplemental Life** - $5,000 increments up to 10x your annual salary.			
AD & D with dependents - $25,000 increments up to 10x your annual salary.			
AD & D without dependents - $25,000 increments up to 10x your annual salary.			
Dependent Life – Available during 31-day initial enrollment period or within the first 60 days of marrying or 91 days of having your first child.			
***Spouse Supplemental Life -** $5,000 increments up to the amount you elected for employee supplemental life.			
***Long Term Disability (LTD) Insurance**			

***EVIDENCE OF INSURABILITY (EOI)** - If you elect an increase of more than $10,000 to Supplemental Life, any increase to Spouse Supplemental Life, and/or a new election of Long Term Disability (LTD), you must complete an EOI. You can access the EOI form on the HCBD website at www.benefits.mt.gov/Forms. **Please be aware, you will not receive a reminder regarding the requirement to complete the EOI. Failure to complete EOI will result in NO Life Insurance increases beyond the $10,000 allowed without EOI. If you do not currently have Supplemental Life or LTD, you will not qualify for any options without EOI.**

ACTION REQUIRED ON NEXT PAGE!

FLEXIBLE SPENDING ACCOUNTS (FSA) – If you are adding a spouse/domestic partner or dependent, you may increase your FSA contribution. If you are deleting a spouse/domestic partner or dependent, you may decrease your FSA contribution.

Medical Expense FSA ❑Leave as-is ❑Change to _____**YEARLY AMT (**$120 min/$2,600 yearly max)

Dependent/Child Care FSA ❑Leave as-is ❑ Change to _____**YEARLY AMT (**$120 min/$5,000 household yearly max)

READ AND SIGN

I request the election changes indicated, and authorize the associated payroll deduction.

Flexible Spending Account(s) ("FSA") - If I elect to participate in the FSA(s) for the Plan Year, I authorize the State of Montana to reduce my gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Plan Year, and only eligible expenses incurred during the Plan Year may be claimed for reimbursement. I realize this election will NOT continue for subsequent Plan Years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this Plan Year.

Adding Spouse/Domestic Partner and/or Dependents - I understand if I am adding a new spouse to my Plan, deductions for my spouse will default to the pre-tax plan. I understand if I am adding a new domestic partner and my domestic partner does not qualify as a tax dependent, deductions for his/her benefits will come out of my check after-tax. I will receive a Declaration of Tax Status form to complete and failure to return the Declaration of Tax Status form will result in my spouse/domestic partner being defaulted to a non-qualified tax status. I also understand if the tax status of a currently covered spouse/domestic partner has changed, it is my responsibility to update HCBD.

I understand by signing below, I agree to the above Authorization Terms.

Signature:_____Date:_____

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

- ظة: إذا تكنت تحتدث اذرك اللغة، فإن خدمات المامعدسة اللوغةي تتوافر لك ابلمجن. التصـ ربمة 855-999-1063)رقم . 1062-999-855-1 :مبكهافـة الصم والوحلم
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063)
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email: John Pavao, State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3984 Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)