NEW EMPLOYEE ENROLLMENT FORM

INSTRUCTIONS & DEADLINE FOR ENROLLMENT

Use this form to enroll in the State of Montana Benefit Plan (State Plan).

- This form **must be postmarked or returned within 31 days of your date of hire** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Your benefits will be effective retroactive to your date of hire.
- If you do not submit your benefit enrollment form within 31 days of your date of hire, you will not be enrolled in the State Plan and ALL of your benefit options will be waived.
- 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 ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

SOCIAL SECURITY # ____-____-_____ AGENCY NAME _____ DATE OF HIRE _____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

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

- ☐ I have been given the opportunity to enroll in the State Plan and decline participation at this time. I understand if I decide to participate after my initial 31 day enrollment period, I may have limited opportunity to enroll at a later date.

COVERAGE ELECTION – Enter the information for yourself and any spouse/domestic partner and/or dependent child(ren) you would like to add to your Medical and/or Dental coverage.

- Employees enrolled on the State Plan must have Medical, Employee Dental, and Basic Life Insurance.
- Please refer to the current Summary Plan Document (SPD), http://benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

Name	Coverage (Circle M for Medical and/or D for Dental)	Birthdate	Relationship	SSN
	(M) (D)		**Employee**	
	M D			
	M D			
	M D			
	M D			
	M D			
	M D			
	M D			
	M D			

VERIFICATION OF ELIGIBILITY

If you are adding a spouse/domestic partner and/or dependent child(ren) to your medical and/or dental coverage, you are required to submit the verification of eligibility documentation as outlined below to HCBD within 60 days of your date of hire. You may submit this information via email to benefitsquestions@mt.gov with the subject line, "New Hire Enrollment." You can also mail it to HCBD, attention: "New Hire Enrollment" 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.

TURN OVER - ACTION REQUIRED ON BACK!

JOINT CORE ELECTION – For spouses/domestic partners who are both employed by the State and have covered dependents. Your spouse/domestic partner must also submit a mid-year change form to elect Joint Core status.

- ❑ Elect Joint Core - JointCore Partner and SSN _____

VISION HARDWARE COVERAGE - 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.

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	Yes	No	Amount Requested
Basic Life Insurance (Required) - $14,000	**X**		$14,000
Employee Supplemental Life* – 1 x Annual Salary rounded to next highest $5,000 in $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** - $2,000 spouse, $1,000 each dependent child			**Not Available**
Spouse Supplemental Life* - $5,000 increments up to the amount you elected for Employee Supplemental Life.			
Long Term Disability (LTD) Insurance			**Not Available**

***EVIDENCE OF INSURABILITY (EOI) –** Evidence of Insurability is not required if you enroll within 31 days from your date of hire. EOI is required for late enrollees. EOI is required for Employee Supplemental Life elections of more than 1x your annual salary and Spouse Supplemental Life elections over $10,000. You can access the EOI form 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 beyond the amount allowed without EOI.**

**Dependent Life is only available during your initial 31 day enrollment period or within the first 60 days of acquiring a spouse or your first child.

BENEFICIARY DESIGNATION – This designation will apply to the Life and Long Term Disability coverage elections made above.

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, or as provided under the State Plan's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary – John Q. Doe, 40%."
- If you need more space, please attach additional page with the information below included.

Primary or Contingent	Full Name	Address	Date of Birth	Relationship	% of Benefit

FLEXIBLE SPENDING ACCOUNTS (FSA) - You must elect an account and indicate an amount to enroll in an FSA. If you elect an FSA, you must also participate in the Pre-Tax Plan. Calculate the yearly FSA amount keeping in mind the yearly amount must be divisible evenly by the pay periods remaining in the Plan Year. Your election will be adjusted to an even amount if necessary.

- ❑ Medical Expense FSA _____**YEARLY AMT** ($120 min/$2499.84 yearly max)
- ❑ Dependent/Child Care FSA _____**YEARLY AMT** ($120 min/$4999.92 household yearly max)

SIGNATURE REQUIRED ON NEXT PAGE!

EMPLOYEE ID# _____ LAST NAME _____ FIRST NAME _____ MI _____

READ AND SIGN

I request the elections indicated, and authorize the associated payroll deduction.

Flexible Spending Account(s) ("FSA") - If I elect to participate in the FSA(s), 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.

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, deductions for his/her benefits will come out of my check after-tax. I understand it is my responsibility to make any changes to my tax status by completing a Declaration of Tax Status form and sending the form back to benefitsquestions@mt.gov by November 15, 2016. I understand failure to return the Declaration of Tax Status form will result in my spouse/domestic partner being defaulted to the tax status indicated above. 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 the tax status cannot change mid-year unless I have a qualified change which is outlined in the current Summary Plan Document.

By signing below, I certify that the above information is correct, and my coverage elections are considered an irrevocable agreement for this benefit year and I understand I can only enroll dependents in my State Plan during my initial enrollment or with a Special Enrollment Period as defined in the Summary Plan Document.

Signature:_____Date:_____

Language Assistance – General Taglines

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

- ظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-999-1063 (رقم 1-855-999-1062 :مكبهاتف اصلم والحولم
- 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)