RETIREE ELECTION FORM

INSTRUCTIONS & DEADLINE FOR ELECTION – Use this form to elect the State Plan coverage you would like upon retiring from the State of Montana.

- This form and payment **must be postmarked or returned within 60 days of the date your active service ends** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.
- Include a copy of your, and if applicable your spouse/domestic partner and/or dependent(s), Medicare card if Medicare eligible.
- See the Retirement Health Benefits Planning Book for full details about your State Plan benefit options in retirement.

PERSONAL INFORMATION

Snowbirds: If you plan to live somewhere other than this address for part of the year, be sure to let HCBD know!
EMPLOYEE ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

SOCIAL SECURITY # ____-____-_____ RETIREMENT DATE _____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

OPTION TO TERMINATE BENEFITS – You may find it beneficial to consider switching from the State Plan to a plan available on the Health Insurance Marketplace (under 65) or a Medicare Supplement or Advantage Plan (over 65). Please be aware, as of January 1, 2017, the State Plan is eliminating Retreat Rights, so if you elect to terminate your State Plan coverage, you WILL NOT have an opportunity to reenroll at a future date.

❑ I would like to terminate my State Plan coverage effective _____ (Month/Year).

RETIREE COVERAGE ELECTION – The Previous Coverage box reflects the types of coverage you and any covered dependents had at the time you terminated from the State Plan. Please complete the Coverage to Continue box and indicate the coverage you wish to elect for Retiree coverage, you may only elect to continue the coverage that was in effect when your active employment ended. Cross out a member's name if you do not want him/her to continue coverage.

- Non-Medicare Retirees (under 65) on the State Plan must be enrolled in Medical, Dental, and Basic Life Insurance.
- Medicare Retirees (over 65) are not required to have Dental coverage and are not eligible for Basic Life Insurance.
- You and/or dependent(s) must be enrolled in the Medical Plan to be eligible for Vision Hardware coverage. All dependents enrolled on the Medical Plan will have Vision Hardware coverage.
- Please refer to the current Summary Plan Document (SPD), http://benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

Previous Coverage (M for Medical, D for Dental, V for Vision Hardware)	**Name**	**Coverage to Continue** (Circle M for Medical, D for Dental, V for Vision Hardware)	**Birthdate**	**Relationship**	**SSN**
		M D V		**Retiree**	
		M D V			
		M D V			
		M D V			
		M D V			

MEDICARE STATUS – If you or your spouse/domestic partner is Medicare eligible (over 65) you must enroll in Medicare parts A and B and provide HCBD with a copy of your Medicare card. The State Plan will serve as your Medicare Part D coverage.

❑ I am Medicare eligible ❑ My spouse/domestic partner or dependent child(ren) is/are Medicare eligible

METHOD OF PAYMENT – Select one of the payment methods below.

- ❑ Monthly deductions from MPERA benefit.
- ❑ Monthly self-payment to Health Care & Benefits by check and coupon.
- ❑ Electronic deduction from checking or savings. You will need to complete the Electronic Benefits Payment Deduction Authorization Form to activate this option.

SIGNATURE

I request the changes indicated above. I understand if my spouse or I become Medicare-eligible my spouse or I must enroll in both MEDICARE PART A and MEDICARE PART B as of the first of the month of eligibility. I understand enrollment in any Medicare Part D (drug plan) beside the Navitus MedicareRx Prescription Drug Plan (PDP) contracted through the State Plan is NOT permitted and would result in the termination of all my State Plan benefits. I understand I and/or my spouse is responsible for proper Medicare enrollment and that proof of Medicare enrollment will be required by HCBD.

Signature:_____Date:_____

Language Assistance – General Taglines

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

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- 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)
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- 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)

HCBD USE ONLY	MPERA USE ONLY
Retiree Coverage Effective: _____	MPERA Deduction to Begin: _____
Total Payment Due: _____	Retirement Number: _____
Discount: _____	Date Processed: _____
Authorized by: _____	Authorized by: _____

RETIREE PREPAYMENT OPTION FORM

INSTRUCTIONS & DEADLINE FOR PREPAYMENT – Use this form to elect to prepay your State Plan coverage from your final paycheck.

- This form must be submitted to your agency payroll department prior to your termination date in order to have deductions taken from your final paycheck.

PERSONAL INFORMATION

Snowbirds: If you plan to live somewhere other than this address for part of the year, be sure to let HCBD know!

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

SOCIAL SECURITY # ____-____-_____ RETIREMENT DATE (LAST DAY WORKED) _____

TERMINATION PAY PERIOD ENDING _____

PREPAY BENEFTIS – The prepayment option is for those terminating employees who participate in the pre-tax plan and wish to pay future Retiree benefits from their final paycheck on a pretax basis.

NOTE: Benefits will be taken from the final paycheck on a pretax basis as long as the employee is in the pretax plan. If not, then benefits are taken after tax. Prepayments is limited to the benefits payments for the months remaining in the current Plan Year. No refund of prepaid payments is available. This means that you should NOT select this option if there is a chance you, a covered spouse, or your covered child(ren) will cease to be enrolled on the State Plan during the prepaid period or if you or your spouse will become Medicare eligible before the end of your prepaid period.

NOTE: If you have not received your Medicare card but are eligible for Medicare, you WILL receive the lower Medicare rate when your payment is calculated. If you are eligible for Medicare (or when you become Medicare eligible), the State Plan will coordinate your State Plan benefits with the benefits you are eligible for with Medicare. Even if you do no enroll in Medicare Parts A and B, the State Plan will pay claims as if you were enrolled, which WILL result in larger out-of-pocket costs for you.

RETIREE COVERAGE ELECTION – In order to elect the prepayment option, you must:

- Complete the Retiree Election Form and any of the applicable forms that pertain to you.
- Complete the Employee Section of the Retiree Prepayment Option Form.
- Return all forms to your agency payroll department prior to your termination.

EMPLOYEE COMPLETE

- ❑ I am electing continuation in the State of Montana Benefit Plan (State Plan) as a Retiree.
- ❑ I elect to have _____ months of benefits payments withheld from my final paycheck. (Limited to the remainder of the current Plan Year and availability of funds in final paycheck.)

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❑ I am Medicare eligible ❑ My spouse/domestic partner or dependent child(ren) is/are Medicare eligible

Signature:_____Date:_____

FOR AGENCY PERSONNEL USE ONLY

Determine the total additional amount to be withheld from the final paycheck. List the month/year of coverage, payment for each type of coverage and total payments for each month (do not include the grandfathered month). Use Medicare Rates for Retirees when applicable.

Month/Year	Medical	Dental	Vision Hardware	Basic Life	Medical FSA	Dependent FSA	Admin Fee	Debit Card Fee	Total
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
						NA			
TOTALS									

HEALTH CARE & BENEFITS USE ONLY
Wellness Incentive:
Grandfathered Month:
Grandfathered Month Out of Pocket:
Half Month Collected:

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