

2012 OPTION 2

HEALTH BENEFIT ELECTION

FOR STATE OF MONTANA LEGISLATORS

Complete this two sided form to designate your election to waive coverage (health, dental, and life) under the State of Montana Employee Benefits Plan and apply the State Share contribution to other health benefits coverage. ***The Contribution Statement on the back of this page must also be completed.***

Employer Providing Alternate Coverage

Address

City State Zip

Phone

Insurance Carrier

Address

City State Zip

Policy Number

I understand that the State contribution will be paid on the last day of each month. I further understand that it remains my responsibility to pay any portion of the alternate coverage contribution which is over the current State contribution. I understand that my COBRA rights are voided if I choose this option.

Signature

Date

CONFIRMATION STATEMENT

Legislator's Name

Social Security Number

Address

City

State

Zip

Phone Number

ALTERNATE COVERAGE INFORMATION

Total Monthly Contribution: \$ _____

Employer Contribution: \$ _____

Remaining Balance: = \$ _____ **

** The State of Montana will pay this amount providing it does not exceed the monthly State Contribution of \$733.00 for 2012.

Make Check Payable to: _____

Mail Check to: _____

Instructions: Complete all requested information regarding the Legislator and the Alternate Insurance. **This information must be accompanied with documentation from your Insurance provider showing your out-of-pocket contribution costs.** You are required to notify the Health Care & Benefits Division of any changes in your alternate coverage. We request this notification within 60 days of the effective date of the change. We are unable to adjust for contribution change amounts beyond 60 days. Payments for Alternate Coverage are processed on the last working day of each month.