

2016 OPTION 2
HEALTH BENEFIT ELECTION
FOR STATE OF MONTANA LEGISLATORS

Complete this two-sided form to designate your election to waive coverage (health, dental, vision, and life) under the State of Montana Employee Benefits Plan and apply the State share contribution up to \$976 to other health care 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 share will be paid on the last day of each month and will reimburse out of pocket expenses for the following month. Plan options available for reimbursement are medical, dental, vision and life benefits. All forms and documentation for mid-year changes must be received to Health Care and Benefits Division no later than the 25th of each month. This ensures payment will be issued on the last day of the month. If documentation is not received by the deadline, **no retroactive payments will be issued.** I further understand that it remains my responsibility to pay any portion of the alternate coverage payment which is over the current State contribution. I understand that my COBRA rights are voided if I choose this option.

Signature

Date

CONTRIBUTION STATEMENT

Legislator's Name

Address

City State Zip

Phone Number

ALTERNATE COVERAGE INFORMATION

Total Monthly Contribution: \$ _____

Employer Contribution: \$ _____

Remaining Balance: = \$ _____ **

** The State of Montana will pay up to this amount providing it does not exceed the monthly State share of \$976 for 2016.

Make Check Payable to: _____

Mail Check to: _____

Instructions: Complete all requested information regarding alternate coverage. **Attach documentation from your health care benefits plan showing your out-of-pocket costs and employer contribution.** Notify Health Care & Benefits Division of any **mid-year changes** in your alternate coverage; submit your newly completed Option 2 form to Health Care and Benefits Division by the 25th of the month. Payments for alternate coverage are processed on the last working day of each month. If documentation is not received by the deadline, **no retroactive payments will be issued.** Submit form to: Health Care and Benefits Division, PO Box 200130, Helena MT 59620-0130.