

**State of Montana Employee Group Benefits Plan  
New Enrollment Form**

*Complete instructions and Definitions on the Back of this Form*

*You must complete and return this form to Health Care and Benefits Division within 31 days of first day of employment.*

Last Name	First Name	MI	Social Security #
Street or PO Box		Phone #	SABHRS Employee ID#
City	State	Zip	Agency Name

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

**PART 1 – NEW ENROLLMENT**

**1. Date Employed:** \_\_\_\_\_

I am currently a dependent on the State Plan under: Name \_\_\_\_\_ SS# \_\_\_\_\_ Agency \_\_\_\_\_

**2. Select Coverage**

Check Coverage Elected	Medical	Dental	Vision Hardware
Myself only			<i>If you chose Vision Hardware coverage, it will apply to everyone on your medical plan.</i>  <input type="checkbox"/> Yes <input type="checkbox"/> No
Myself & spouse			
Myself & child(ren)			
Myself & family			
<b>Joint Core*</b>			

**3. Select Pre-tax Plan**

*The default will be pre-tax unless otherwise noted.*

Deduct my contributions **before-tax**  
OR  
 Deduct my contributions **after-tax**

**4. Select Dental Plan**

Basic  
 Premium

\*Joint Core Partner's Name: \_\_\_\_\_ SS# \_\_\_\_\_ Agency \_\_\_\_\_

**PART 2 – DEPENDENTS**

Check One	Check Coverages	Check Relationship	Name	Birth Date	Social Security #	Tax Status Declaration <i>See below &amp; back of form</i>
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Spouse				<input type="checkbox"/> Qualified <input type="checkbox"/> Non-Qualified
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				NA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				NA
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				NA

**DECLARATION OF TAX STATUS:** My signature in Part 3 indicates that I have received the necessary Declaration of Tax Status flowcharts and have made the corresponding elections for spouse/domestic partner listed above. I have read the Declaration of Tax Status instructions and information on the back side of this form and am aware of the implications of my choices therein. I understand that the State of Montana has a legitimate need to confirm whether my spouse/domestic partner meets the appropriate definition(s) for tax purposes for the medical, dental, and/or vision plans. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I agree to notify Health Care and Benefits Division if there is any change in these circumstances within thirty (30) days of the change. I am aware that changes may impact the tax treatment of my benefits coverage.

**FSA Monthly Election Amount**

*Make certain your total monthly election is divisible by 2.*

Medical Expense FSA	\$10min/\$208.32 max		/month
Dependent Care FSA (Day Care Expenses)	\$10min/\$416.66 max		/month
Administrative Fee			\$2.26
<b>Total Monthly Election</b>			/month

**PART 3 – SIGNATURE / CERTIFICATION:** I have read the informational material describing Flexible Spending Accounts and understand the participation conditional and requirements. I request participation in the FSA(s) listed above for the current benefit year, and authorize the State of Montana to reduce gross salary by the amounts indicated or, in the event of self-paying, to pay the amount indicated. I understand that my election amount will remain in effect for the entire benefit year, and only expenses incurred during the time contributions have been made can be claimed for reimbursement. I realize that this agreement will NOT continue for subsequent benefit years. This agreement revokes all prior State of Montana Flexible Spending Account Enrollment/Change and Salary Reduction Agreements signed by me.

I elect the benefits coverage or changes indicated above and have attached appropriate documentation of change. By signing below, I certify that: **1)** The above information is correct, and my coverage elections are considered an irrevocable agreement for this benefit year; **2)** I agree to pay the necessary benefits payment to effect this coverage and authorize payroll deduction, if applicable; and **3)** I understand I can only enroll dependents in my medical plan during my initial enrollment or with a Qualifying Event, as described on the back of this form.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HCBDB USE ONLY**

Effective Date:

System Entry Date:

Entered by:

## INSTRUCTIONS

**Return completed form to Health Care and Benefits Division, PO Box 200130, Helena MT 59620-0130**

**WAIVER OF COVERAGE** – If waiving enrollment in the health plan, complete the Name/Address section and mark the Waiver of Coverage box. Sign/date the form in Part 3. Members must have a qualifying event to waive coverage mid-year.

**NEW ENROLLMENT/RE-ENROLLMENT** – If enrolling for coverage: **a)** complete all applicable sections of Part 1, including the Pre-Tax section; and **b)** list the names and other information for all *dependents*\* to be covered in Part 2.

\*The **Joint Core** provision gives employees whose spouse also works for the State medical & dental coverage for dependent child(ren) with only one family deductible and one out-of-pocket maximum and may have a lower contribution. Longevity determines the primary joint core policy holder. The primary joint core policy holder elects vision hardware for the entire family.

**Eligible Dependent** is defined in the Summary Plan Document. It is the employee's responsibility to enroll, re-enroll, or add dependents that satisfy the definition of eligible dependent and to remove from coverage any dependents that become ineligible for any reason.

Contact your agency benefits personnel immediately when dependents become ineligible. *The employee is responsible for repayment of any claims dollars paid for an ineligible dependent which exceed contributions collected. Also, any excess contributions paid for coverage of a dependent who ceases to be eligible cannot be refunded if you are in the Pre-tax Plan.*

**EFFECTIVE DATE** – All effective dates are determined as follows:

**Effective Date for New Enrollment: Date of hire or newly eligible**

### **DECLARATION OF TAX STATUS** –

The State of Montana is required by the Internal Revenue Service to apply the proper tax treatment (before or after-tax) to benefits for spouse/domestic partner currently enrolled in medical, dental, or vision benefits. Therefore, it is important that you provide the tax status for each of these individuals enrolled. The qualification of these individuals as your spouse or domestic partner for tax purposes does not affect their eligibility for the medical, dental, or vision plans, but does impact the tax treatment of that coverage.

Flowcharts are provided to assist you in determining and verifying the tax status of your spouse or domestic partner. The flowcharts provide the most complete overview of the tax rules possible; however, given the complexity of those rules, we recommend that you consult with your tax advisor regarding your specific circumstances.

For each spouse/domestic partner enrolled in medical, dental, or vision benefits, check one of the two boxes next to their name in Part 2. If you do not indicate a the tax qualification status, contributions for those persons will be taken on an after-tax basis, and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for those persons who will be added to your taxable income. With respect to any person for whom you have checked "Non-qualified," contributions for those persons cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for these persons will be added to your taxable income.