

INDIVIDUAL BENEFITS STATEMENT FORM

Empl ID:  
Agency:  
Location:

Health Care and Benefits Division  
PO Box 200130  
Helena MT 59620-0130

EMPLOYEE NAME  
EMPLOYEE ADDRESS  
EMPLOYEE ADDRESS  
EMPLOYEE CITY STATE ZIP

**INSTRUCTIONS & DEADLINE FOR ELECTIONS:** Review your elections carefully by verifying the types and amounts of coverage, reviewing benefit offerings in your annual change booklet, and making any necessary changes to the appropriate sections of this form or online by the **October 22, 2014** deadline. All forms must be postmarked or returned to Health Care and Benefits Division by **October 22, 2014**. Forms may be sent through the U.S. Postal Service, through State of Montana (deadhead) mail service, or dropped off at 100 N Park, Suite 320 in Helena. Giving your form to your employer or payroll personnel does not constitute filing with the Health Care and Benefits Division. **If you completed your enrollment online, do not submit this form.**

CURRENT BENEFITS	*2014 COVERAGE	2014 BENEFIT PAYMENT	2015 BENEFIT PAYMENT
Medical**	:	:	:
Dental	:	:	:
Vision Hardware - Re-enrollment Required	:	:	:
Basic Life	:	:	:
Dependent Life	:	:	:
Employee Supplemental	:	:	:
Spouse Supplemental	:	:	:
AD&D	:	:	:
Pre-Tax Plan	:	:	:
Long Term Disability	:	:	:
State Share	:	:	:
Live Life Well Discount***	:	:	:
<b>TOTAL OUT-OF-POCKET BENEFIT PAYMENTS</b>	:	:	:

\*As of September 11, 2014

\*\* Please note, if you are enrolled in the Classic plan, this medical plan is no longer available and you will automatically be enrolled in the Capitol plan. The 2015 benefit payment quoted above is for the Capitol plan.

\*\*\*As of August 19, 2014. If you completed incentive activities after this date, your discount will not be reflected in this statement. You have until October 31, 2014 to complete all incentive activities to qualify for your 2015 life life well discount. Refer to your change booklet for additional information. Take into consideration your incentive activities when calculating your out-of-pocket costs.

**I. PRE-TAX PLAN** - Your current election will automatically continue, unless you indicate otherwise below.

- Continue with current coverage
- Yes, I want my deductions withheld on a pre-tax basis  No, I want my deductions withheld on an after-tax basis

**Add or delete dependents (s):** Verify that the information below is accurate. Make changes where necessary. Please remember, employees are required to participate in medical, dental, and basic life. During this annual change period, dependent children under 26 years of age and a spouse or domestic partner may be added. To delete/add a dependent from coverage, check the Delete/Add box next to each dependent's name and **circle** the type of coverage to be deleted/added.

Delete	Add	Coverage**	Name	Birth date	Rel*	Tax Status	SSN
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

\*Rel. = Relationship • E = Employee • SP = Spouse • D = Daughter • S = Son • X = Disabled

\*\*Coverage • M=Medical • D=Dental • V=Vision

