ACTIVE DUTY MILITARY LEAVE ELECTION FORM

INSTRUCTIONS & DEADLINE – Use this form to make changes to your State of Montana Benefit Plan (State Plan) coverage elections while you are on active duty military leave for more than 31 days.

- Employees on active duty military leave who choose to remain on the State Plan must remain on medical benefits. Any coverage you remove may be reinstated within 31 days of your return from active duty military leave.
- While on active duty military leave, you may continue to receive the employer contribution. Please contact the State Human Resource Division (406) 444-3871 for assistance in determining how long the employer contribution will be available to you. You will be billed for any benefit contributions you owe over the employer contribution amount twice a month (each State Pay period).
- This form **must be postmarked or returned before you leave for active duty military leave** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Please provide a copy of your active duty military order.
- If you would like to prepay your benefit contributions with your final paycheck before military leave, complete and return this form before your final paycheck is issued to your agency payroll department. Your agency payroll department must complete the "For Agency Personnel Use Only" section and then submit the form to the Health Care & Benefits Division. Prepayment is limited to the benefit contributions for the months remaining in the current Plan Year.
- If you do not submit this election form within 31 days of your military active duty leave, your State Plan coverage will be adjusted to reflect only the benefits you are eligible for during military active duty leave and you will be billed for any benefit contribution you owe over the employer contribution amount.
- The Health Care & Benefits Division (HCBD) website, benefits.mt.gov, includes important benefit information to help you understand State Plan contributions, coverages, and benefit options.

PERSONAL INFORMATION

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

DATE OF BIRTH ____-____-_____ DATE CALLED TO ACTIVE DUTY _____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

WAIVER OF COVERAGE – Check this box if you would like to waive State Plan coverage while on active duty military leave.

❑ Check this box if you would like to waive State Plan coverage for yourself and any covered spouse/domestic partner and/or dependent child(ren) while on active duty military leave. You may re-enroll by completing the Mid-Year Charge Form within 31 days of your return from active duty military leave.

COVERAGE ELECTION – Enter the information for yourself and any spouse/domestic partner and/or dependent child(ren) as you would like them covered while you are on active duty military leave.

Name	Coverage (Check M for Medical and/or D for Dental)	Birthdate	Relationship
	☐ M D ☐		**Employee**
	☐ M D ☐		
	☐ M D ☐		
	☐ M D ☐		
	☐ M D ☐		

TOBACCO SURCHARGE – A Tobacco Surcharge applies if you or your covered spouse/domestic partner is a nicotine user.

Read the following definition of Nicotine Free and Nicotine User then answer the questions based upon you/your covered spouse/domestic partner's use of nicotine.

Nicotine: Nicotine is an addictive stimulant proven to have negative health effects that is found in cigarettes, cigars, chewing tobacco, and most vaping products.

Nicotine Free

- You are nicotine free if you have never used nicotine, have quit using nicotine, use only FDA-approved Nicotine Replacement Therapy (NRT), or infrequently use nicotine (less than 4x per month).
- You are nicotine free if you are currently using nicotine but HAVE completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months.
- Answer "No" – I **am not** currently a nicotine user in the question below.

Nicotine User

- You are a nicotine user if you are currently using nicotine and HAVE NOT completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months. *If you or your covered spouse/domestic partner fits this definition, the surcharge will apply and $30 per month will be charged for the employee who uses nicotine and/or $30 per month if the employee's covered spouse/domestic partner uses nicotine.*
- Answer "Yes" – I **am** currently a nicotine user in the questions below.

Based upon the definition above, **are you currently a nicotine user**?

❑ No, I am not currently a nicotine user. Monthly $30 Tobacco Surcharge will not apply.

❑ YES, I am currently a nicotine user. Monthly $30 Tobacco Surcharge will apply.

Based upon the definition above, **is your covered spouse/domestic partner currently a nicotine user**?

- ❑ No, my covered spouse/domestic partner is not currently a nicotine user. Monthly $30 Tobacco Surcharge will not apply.
- ❑ YES, my covered spouse/domestic partner is currently a nicotine user. Monthly $30 Tobacco Surcharge will apply.
- ❑ NA – I do not have a covered spouse/domestic partner.

VISION HARDWARE COVERAGE – Vision Hardware Coverage covers all members enrolled in your Medical Plan.

❑ Continue Vision Hardware Coverage ❑ Waive Vision Hardware Coverage

LIFE INSURANCE – If you elect to stay on the State Plan while on Active Duty Military Service, you will only be eligible for Basic Life Insurance. To Port or Convert your current life insurance coverage during your Active Duty Military Service you should contact BlueCross BlueShield of Montana at (866) 739-4090.

Coverage	Keep the same	Waive	Change	Amount Requested
Basic Life Insurance (Required) - $14,000	**X**	**N/A**	**N/A**	$14,000
Employee Supplemental Life – minimum coverage of 1 x annual salary rounded to next highest $5,000, up to a maximum coverage amount of $1,000,000, must be in increments $5,000	**N/A**	X	**N/A**	
AD & D with dependents - $25,000 increments up to maximum coverage amount of $1,000,000	**N/A**	**X**	**N/A**	
AD & D without dependents - $25,000 increments up to maximum coverage amount of $1,000,000	**N/A**	**X**	**N/A**	
Dependent Life** Option A - $2,000 spouse, $1,000 per child Option B - $4,000 spouse, $2000 per child **If you waive this coverage, you may not be able to reelect it when you return from active duty.**	N/A	X	**N/A**	**NA**
Spouse Supplemental Life* - $5,000 increments up to the amount you elected for Employee Supplemental Life, but not to exceed $500,000	**N/A**	**X**	**N/A**	
Long Term Disability (LTD) Insurance	**N/A**	**X**	**N/A**	**NA**

FLEXIBLE SPENDING ACCOUNTS (FSA) - FSA amount must be divisible evenly by the pay periods remaining in the Plan Year. Your election will be adjusted to an even amount if necessary.

- ❑ Leave my Medical FSA the same
- ❑ Waive Medical FSA
- ❑ Change my Medical FSA to _____**YEARLY AMT** ($120 min/$2,850 yearly max)

**If an employee is ordered or called to active duty for a period of 180 days or more, the employee may request a Qualified Reservist Distribution (QRD). See the Flex Plan Document portion of the Wrap Plan Document for additional details. Otherwise, all plan limitations apply.

- ❑ Leave my Dependent/Child Care FSA the same
- ❑ Waive Dependent/Child Care FSA
- ❑ Change my Dependent/Child Care FSA to _____**YEARLY AMT** ($120 min/$5,000 household yearly max)

READ AND SIGN

I request the election changes indicated. I understand I am responsible for paying any benefit contribution I owe.
Flexible Spending Account(s) (FSA) - If I elect to change my FSA(s) contribution, I realize I will have the opportunity to change it again upon returning from active duty military leave. I understand the elections I submit to HCBD will be binding until I return from active duty military leave unless I or a dependent qualify for a Special Enrollment Period as described in the Wrap Plan Document. I understand by signing below, I agree to the above Authorization Terms.

Signature:_____Date:_____

MILITARY LEAVE PREPAYMENT OPTION SECTION

Complete the following section, in conjunction with your Agency Personnel, to elect to prepay your State Plan coverage from your final paycheck.

- ***In order to have contributions withheld from your final paycheck, this entire form must be submitted to your agency payroll department prior to date you are called to Active Duty.***

PERSONAL INFORMATION

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

DATE OF BIRTH ____-____-_____ Date Called to Active Duty_____

PREPAY BENEFITS – The prepayment option is for those employees called to Active Duty who participate in the State Plan and wish to pay future employee contributions for the current calendar year from their final paycheck on a pretax basis. Prepayment can only be deducted from your last regular paycheck (HCBD is unable to collect from off cycle checks).

NOTE: Benefits will be taken from the final paycheck on a pretax basis. Prepayment is limited to the contributions 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.

ACTIVE DUTYMILITARY LEAVE– In order to elect the prepayment option, **you must continue enrollment in State Plan coverage while on Active-Duty Military Leave** and:

- Complete the Active-Duty Military Leave Election Form, including the Military Leave Prepayment Option Section.
- Return entire form to your agency payroll department prior to your termination.

EMPLOYEE COMPLETE

- ❑ I am electing continuation in the State of Montana Benefit Plan (State Plan) while on active duty.
- ❑ I elect to have _____ months of contributions withheld from my final paycheck. (Limited to the remainder of the current Plan Year and availability of funds in final paycheck.)

Signature:_____Date:_____

FOR AGENCY PERSONNEL USE ONLY

Agency Personnel – In order to complete the pre-payment request for your employee, HCBD needs the amount that will be available from the employee's last paycheck to pre-pay State Plan contributions employee benefits. Employees going out on Active-Duty Military Leave are only able to pre-pay from their last regular payroll check (HCBD cannot collect from off-cycle checks). In addition, employees are only able to prepay their State Plan contributions for the current Plan Year (calendar year). Please enter the amount that will be available for the employee to prepay from their last regular paycheck below:

$

Agency Rep Signature:_____
Agency Rep Phone Number: _____
Agency ID:_____
Date: _____

Language Assistance – General Taglines

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

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 1-866-270-3877（TTY：711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-668-072-7783 (رقم هاتف الصم والبكم: 117).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).

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 the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email: State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@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)