2025 NEW LEGISLATOR ENROLLMENT FORM

INSTRUCTIONS & DEADLINE FOR ENROLLMENT

Use this form to enroll in the State of Montana Benefit Plan (State Plan).

- This form **must be postmarked or returned by February 6, 2025** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130. Your benefits will be effective retroactive to January 6.
- You may also complete your New Legislator Enrollment online at benefits.mt.gov. To access the enrollment system, go to benefits.mt.gov and click on the 'Benefit Enrollment and Changes' button. First time users: Register your User Name and Password and answer a few security questions. The case-sensitive company key is stateofmontana.
- If you do not submit your benefit enrollment form by February 6, 2025, you will not be enrolled in the State Plan and ALL of your benefit options will be waived.
- The Health Care & Benefits Division (HCBD) website, benefits.mt.gov, includes important benefit information to help you understand State Plan rates, coverages, and benefit options.

PERSONAL INFORMATION

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

LAST FOUR OF SSN _____ AGENCY NAME _Legislative Branch_____ DATE OF HIRE _____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

WAIVER OF COVERAGE – Legislators who waive State Plan coverage may have additional options available to them. To waive your coverage, you must fill out the Legislator Opt Out/Waiver Form. Request this form by calling HCBD at (800) 287-8266.

COVERAGE ELECTION – Enter the information for yourself and any spouse/domestic partner and/or dependent child(ren) you would like to add to your Medical and/or Dental coverage.

- Legislators must enroll in Medical to enroll in any other State Plan benefits. Medical includes Medical, Prescription, Basic Vision, and Basic Life.
- Please refer to the current Wrap Plan Document (WPD), benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

Name	Coverage (Check M for Medical and/or D for Dental)	Birthdate	Relationship	SSN
	☐ M ☐ D		**Legislator**	
	☐ M ☐ D			
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VERIFICATION OF ELIGIBILITY

If you are adding a spouse/domestic partner and/or dependent child(ren) to your medical and/or dental coverage, you are required to submit the verification of eligibility documentation as outlined below to HCBD by March 6, 2025. You may submit this information via email to benefitsquestions@mt.gov with the subject line, "2025 New Legislator Enrollment." You can also mail it to HCBD, attention: "2025 New Legislator Enrollment" PO Box 200130, Helena, MT 59620.

- Dependent Children
  - A copy of your child's/children's birth certificate(s), adoption order, pre-adoption order; or
  - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.
- Spouse
  - A copy of your certified marriage certificate; or
  - A copy of the front page of your tax return showing your tax filing status as "married" (you may black out any financial information); or
  - A copy of your recorded and notarized Affidavit of Common Law Marriage (available on the HCBD website at http://benefits.mt.gov/forms).
- Domestic Partner
  - A Declaration of Domestic Partner Relationship and Affidavit of Shared Residence forms (available on the HCBD website at http://benefits.mt.gov/forms); AND
  - A copy of mutually-granted powers of attorney or health care powers of attorney; or
  - A copy of mutual designations of primary beneficiary in wills, life insurance policies or retirement plans.
- Grandchild(ren)
  - A copy of a court-ordered custody agreement or legal guardianship.
- Stepchildren
  - Required documentation listed above for Domestic Partner or Spouse, if individual is not enrolled; AND
  - A copy of your stepchild's/stepchildren's birth certificate(s), adoption order, pre-adoption order; or
    - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

JOINT CORE ELECTION – For spouses/domestic partners who are both employed by the State and have covered dependents. Your spouse/domestic partner must also submit a mid-year change form to elect Joint Core status.

❑ Elect Joint Core – Spouse/Domestic Partner's Name & Last Four of SSN _____

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 legislator who uses nicotine and/or $30 per month if the legislator'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 - You and/or your dependent(s) must be enrolled in the Medical Plan to be eligible for Vision Hardware. If you check YES below **all** dependents enrolled on your Medical Plan will have Vision Hardware Coverage.

❑ Yes, I want to enroll. ❑ No, I do not want to enroll.

LIFE INSURANCE – Put an X in the box of the option you would like to elect.

Coverage	Yes	No	Amount Requested
Basic Life Insurance (Required) - $14,000	**X**		$14,000
Legislator Supplemental Life* – $5,000 increments up to a maximum coverage amount of $1,000,000. Minimum election amount must be $25,000.			
AD & D with dependents - $25,000 increments up to a maximum coverage amount of $1,000,000.			
AD & D without dependents - $25,000 increments up to a maximum coverage amount of $1,000,000.			
Dependent Life Insurance Option A - $2,000 spouse, $1,000 per child Option B - $4,000 spouse, $2,000 per child	**Check Coverage Option** **A** ☐ **B** ☐		**Not Available**
Spouse Supplemental Life* - $5,000 increments up to the amount you elected for Legislator Supplemental Life, up to a maximum of $500,000.			

***EVIDENCE OF INSURABILITY (EOI)** – Evidence of Insurability is not required if you enroll by February 6, 2025. EOI is required for late enrollees. EOI is required for Legislator Supplemental Life elections of more than $25,000 and Spouse Supplemental Life elections over $10,000. You can access the EOI form at benefits.mt.gov/Forms. **Please be aware, you will not receive a reminder regarding the requirement to complete the EOI. Failure to complete EOI will result in NO Life Insurance beyond the amount allowed without EOI.**

**Dependent Life is only available during your initial 31-day enrollment period or within the first 60 days of acquiring a spouse or your first child.

BENEFICIARY DESIGNATION – This designation will apply to the life coverage elections made above.

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the

written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, or as provided under the State Plan's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary – John Q. Doe, 40%."
- If you need more space, please attach additional page with the information below included.

Primary or Contingent	Full Name	Address	Date of Birth	Relationship	% of Benefit

READ AND SIGN

I request the elections indicated, and authorize the associated payroll deduction. In the event I am unable to print and sign this form, or add my electronic signature, I will type my name in the signature line below and return to HCBD via email from my State email account. HCBD will use the State email account as validation for signature and will maintain such record with this form.

I understand if I am adding a new spouse to my Plan, deductions for my spouse will default to the pre-tax plan. I understand if I am adding a new domestic partner, deductions for his/her benefits will default to after-tax deductions. I understand it is my responsibility to make any changes to my tax status by completing a Declaration of Tax Status form and sending the form back to benefitsquestions@mt.gov. I understand failure to return the Declaration of Tax Status form will result in my spouse/domestic partner being defaulted to the tax status indicated above. I also understand if the tax status of a currently covered spouse/domestic partner has changed, it is my responsibility to update HCBD. I understand the tax status cannot change mid-year unless I have a qualified change which is outlined in the current Wrap Plan Document.

By signing below, I certify that the above information is correct, and my coverage elections are considered an irrevocable agreement for this benefit year and I understand I can only enroll dependents in my State Plan during my initial enrollment or with a Special Enrollment Period as defined in the Warp Plan Document.

Signature:_____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 서비ㅅ를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번ㅇ로 전화해 주십시오.

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

เรียน:'U: 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).