SURVIVING SPOUSE/DEPENDENT(S) ELECTION FORM

INSTRUCTIONS & DEADLINE FOR ELECTION – Use this form to elect State of Montana Benefit Plan (State Plan) benefits as a surviving dependent of a Participant or Retiree of the State of Montana.

- This form **must be postmarked or returned within 60 days of the Participant's or Retiree's date of death** to: Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.
- The surviving spouse of a Participant or Retiree may remain a Covered Person of the State Plan as long as the spouse is eligible for retirement benefits accrued by the deceased Participant or Retiree as provided by law unless the spouse has or is eligible to participant in another group health plan with substantially the same or greater benefits at an equivalent cost.
- The surviving children of a Participant may remain Covered Persons of the State Plan as long as they are eligible for retirement benefits accrued by the deceased Participant as provided by law unless they have equivalent coverage with substantially the same or greater benefits at an equivalent cost or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

DECEASED PARTICIPANT OR RETIREE INFORMATION

LAST FOUR OF SSN# _____ LAST NAME _____ FIRST NAME _____ MI ___

DATE OF DEATH _____ TERM DATE _____

CONTACT INFORMATION FOR SURVIVING DEPENDENT ELECTING COVERAGE

If you plan to live somewhere other than this address for part of the year, be sure to let HCBD know!

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

COVERAGE ELECTION – The Previous Coverage box reflects the types of coverage any covered dependent(s) had prior to the death of the Participant or Retiree. Please complete the Coverage to Continue box and indicate the coverage you wish to elect for Survivor coverage, you may only elect to continue the coverage that was in effect for you when the Participant or Retiree was covered.

- You must be enrolled in the Medical Plan to be eligible for Dental or Vision Hardware coverage. All dependents enrolled on the Medical Plan will have Vision Hardware coverage.
- Please refer to the current Wrap Plan Document (WPD), benefits.mt.gov/Publications, for an outline of the State Plan eligibility requirements.

Previous Coverage (M for Medical, D for Dental, V for Vision Hardware)	**Name**	**Coverage to Continue** (Check M for Medical, D for Dental, V for Vision Hardware)	**Birthdate**	**Relationship**	**SSN**
		M☐ D☐ V☐			
		M☐ D☐ V☐			
		M☐ D☐ V☐			
		M☐ D☐ V☐			
		M☐ D☐ V☐			

TOBACCO SURCHARGE – A Tobacco Surcharge applies the surviving spouse if they are a nicotine user. The surviving spouse should read the following definition of Nicotine Free and Nicotine User then answer the questions based upon their use of nicotine. The Tobacco Surcharge does not apply to surviving dependent children.

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, **is the surviving spouse a nicotine user**?

- ☐ No, the surviving spouse is not currently a nicotine user. Monthly $30 Tobacco Surcharge will not apply.
- ☐ YES, the surviving spouse is currently a nicotine user. Monthly $30 Tobacco Surcharge will apply.

SURVIVING SPOUSE/DEPENDENT(S) COVERAGE STATUS – If the surviving spouse or dependent(s) have equivalent coverage with substantially the same or greater benefits at an equivalent cost, the surviving spouse or dependent(s) is not eligible for Survivor coverage. If the surviving dependent(s) is eligible for insurance coverage by virtue of employment of a surviving parent or legal guardian, the surviving dependent(s) is not eligible for Survivor coverage.

- ❑ Surviving spouse or dependent(s) is not eligible for Survivor coverage based upon the coverage status information outlined above.

MEDICARE STATUS – If you, and/or your child(ren), are Medicare eligible you must be enrolled in Medicare Parts A and B and **provide HCBD with a copy of the appropriate Medicare card**. If you, or your child(ren), are Medicare eligible, the State Plan will serve as Medicare Part D coverage for the eligible individual.

- ❑ I am Medicare eligible, and my Medicare Number is: _____
- ❑ My dependent child(ren) is/are Medicare eligible and their Medicare Number is :_____

Please include a copy of the applicable Medicare card when submitting this form.

METHOD OF PAYMENT – Electronic deduction from checking or savings is required.

- ❑ Electronic deduction from checking or savings. You will need to complete the Electronic Benefit Payment Deduction Authorization Form to activate this option.

SIGNATURE – I hereby elect to continue the coverage selected above with the State of Montana Group Benefit Plan (State Plan). This coverage will remain in effect unless I change my coverage election, my dependents lose eligibility, or I fail to pay the required payments by the due date. If I wish to cancel, I must submit my request in writing. I understand that payments may be adjusted for any future increases or decreases in the cost of the coverage(s) I have selected.

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)번ᄋᆞ로 전화해 주십시오.

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