

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 28, 2011** deadline. All forms must be postmarked or returned to Health Care and Benefits Division by **October 28, 2011**. Forms may be sent through the U.S. Postal Service, through the 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 have NO changes, DO NOT wish to enroll in Flexible Spending or Vision, you do not need to return this form. If you completed your enrollment online, do not submit this form.**

BENEFIT OPTIONS	*2011 COVERAGE	2011 Contributions	2012 Contributions
Medical	:	:	:
Dental	:	:	:
Vision - Re-enrollment Required	:	:	:
Basic Life	:	:	:
Dependent Life	:	:	:
Employee Supplemental	:	:	:
Spouse Supplemental	:	:	:
AD&D	:	:	:
Long-Term Care	:	:	:
Pre-Tax Plan	:	:	:
Long Term Disability	:	:	:
State Contribution	:	:	:
Wellness Screening Discount**	:	:	:
TOTAL OUT-OF-POCKET PREMIUM COSTS	:	:	:

\*As of September 14, 2011

\*\*As of September 2, 2011. If you attend a health screening after this date, it will not reflect in this statement. Please take into consideration your health screening participation when calculating your out-of-pocket premium.

**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

**Member & Dependent Information:** Please verify that the information for the following currently covered dependents is accurate. Make changes where necessary. If a dependent's tax status has changed, complete a Declaration of Tax Status form available online at [www.benefits.mt.gov](http://www.benefits.mt.gov). Please note that tax status is only required for your spouse or domestic partner.

Delete	Add	Coverage**	Name	Birth date	Relationship*	Social Security #	Tax Status
<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 • C = Child • X = Disabled • DP = Domestic Partner  
\*\*Coverage • M=Medical • D=Dental • V=Vision

Name:  
Emp ID:  
Home Phone:  
Work Phone:

**II. MEDICAL - Required for all employees. Dependents cannot be added to medical coverage unless there has been a qualifying event (see the annual change booklet).** Delete a dependent from coverage by checking the **delete** box preceding each dependent's name and **circle** the type of coverage to be deleted.

- Continue with current coverage
- Change Medical Plan to:       Traditional                               Blue Choice                               New West
- Elect Joint Core\* (only for married spouses who are both employed by the State and have covered dependents. Your spouse must also submit their Individual Benefit Statement to enroll)  
    \*Employee's Joint Core Partner & SSN \_\_\_\_\_
- Cancel Joint Core (Spouse must also submit their Individual Benefit Statement to cancel.)

**III. DENTAL - Required for all employees**

- Continue with current coverage
- Changes
  - Add a dependent(s): check the **Add** box on this page, write coverage type "D" and the other requested information.
  - Delete a dependent(s): Delete a dependent from coverage by checking the **delete** box preceding each dependent's name and **circle** the type coverage to be deleted.

**IV. VISION COVERAGE - Re-enrollment is required even if you are currently enrolled!** Please choose the appropriate box below. If you wish to cover dependents that are not already listed in the dependent section on the front of this form, please check the **Add** box and write coverage type "V" and the other requested information.

- Employee only coverage                               No, I do NOT want to enroll
- Employee and spouse
- Employee and children
- Employee and family

**V. LIFE INSURANCE - Basis for calculating minimum and maximum coverage \$**

Check out the limited opportunity to get up to \$10,000 in spouse life without evidence of insurability in your Annual Change booklet. Employee may increase existing coverage by \$10,000 without evidence of insurability.

- Continue with current coverage
  - Employee Supplemental Life - \$5,000 increments up to \$500,000** (*Applications will be sent if evidence of insurability is required*)
    - Cancel                               Add or Change - New total amount: \_\_\_\_\_
  - AD & D with dependents - \$25,000 increments up to \$500,000**
    - Cancel                               Add or Change - New total amount: \_\_\_\_\_
  - AD & D without dependents - \$25,000 increments up to \$500,000**
    - Cancel                               Add or Change - New total amount: \_\_\_\_\_
  - Dependent Life**
    - Cancel
  - Spouse Supplemental Life- \$5,000 increments up to 100% of Plan C** (*Applications will be sent if new election exceeds \$10,000*)
    - Cancel                               Add or Change - New total amount: \_\_\_\_\_

**VI. LONG TERM DISABILITY INSURANCE**

- Continue with current coverage                               Yes, I want to enroll                               Cancel

**VII. FLEXIBLE SPENDING ACCOUNTS - Enrollment is NOT automatic! You must select an account and indicate an amount to enroll in an FSA during 2012. If you elect an FSA, you must also participate in the Pre-Tax Plan.** Please calculate the your Monthly & Yearly FSA amount keeping in mind the yearly amount must be divisible evenly by 24. Your election will be adjusted to an even amount if necessary. Include any unused State Benefits Contribution in this amount. There is no monthly fee.

- Medical Expense FSA                              \_\_\_\_\_ **YEARLY AMT** (\$120 min/\$4999.92 yearly max)
- Dependent/Child Care FSA                              \_\_\_\_\_ **YEARLY AMT** (\$120 min/\$4999.92 household yearly max)

**VIII. LONG TERM CARE INSURANCE**

- Continue with current coverage                               Please send me an enrollment kit                               Cancel

**IX. READ AND SIGN**

I request the election changes indicated above and authorize the associated payroll deduction. I understand that it is my responsibility to confirm my 2012 benefit elections during the week beginning November 14, 2011 by accessing the Benefit Summary page located within SABHRS Self Service. I understand that if I am adding a new dependent spouse or domestic partner to my dental or vision benefits, I will receive a Declaration of Tax Status form to complete. Failure to return this form will result in my dependent being defaulted to a non-qualified status. I understand that other application forms may be required for the changes that I have requested, and I am responsible for completing and returning the application materials before processing of my requested changes will continue.

I have read the informational material describing Flexible Spending Accounts and understand the participation conditions and requirements. If selected in section VII, I request participation in the FSA(s) listed above for the 2012 Benefit Year, and authorize the State of Montana to reduce gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Benefit Year, and only eligible expenses incurred during the Benefit Year (2012) may be claimed for reimbursement. I realize this agreement will **NOT** continue for subsequent Benefit Years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this benefit year.

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