

RETIREE BENEFITS STATEMENT FORM

Retiree ID:

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

RETIREE NAME
RETIREE ADDRESS
ADDRESS
RETIREE 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 on this form. All forms must be postmarked or returned to the Health Care and Benefits Division by **October 28, 2011**. Forms may be sent through the U.S. Postal service, or dropped off at **100 N Park, Suite 320** in Helena. **If you have NO changes, AND do not wish to enroll in Vision, then 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	:	:	:
Wellness Screening Discount**	:	:	:
MEDICARE STATUS as of 9/2011 (Your coverage and your spouse's, if applicable, is Non-Medicare unless MDCR [Medicare] is indicated)	:	:	:
TOTAL OUT-OF-POCKET CONTRIBUTION 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 contribution.

Member & Dependent Information: Please verify that the information for the following currently covered dependents is accurate and make changes where necessary.

<u>Delete</u>	<u>Add</u>	<u>Coverage**</u>	<u>Name</u>	<u>Birthdate</u>	<u>Relationship*</u>	<u>Social Security</u>
<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/Retiree • SP = Spouse • D = Daughter • S = Son • X = Disabled

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

I. MEDICAL - Dependents cannot be added to medical coverage unless there has been a qualifying event (see Annual Change booklet). To delete a dependent from coverage, check 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

II. DENTAL - Required for all non-Medicare retirees.

- 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): check the **Delete** box on this page next to the appropriate dependent(s) and **circle** the coverage to be deleted.

III. VISION COVERAGE - Re-enrollment is necessary 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 this form, please check the **Add** box and write coverage type "V" and the other requested information.

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

IV. LONG-TERM CARE INSURANCE

- Please send me an enrollment kit

V. READ AND SIGN

I request the election changes indicated above. I understand that a Confirmation Statement to confirm my 2012 benefits will be mailed the week of November 14, 2011. I understand that other application forms may be required for the changes that I have requested. If so, I understand that I am responsible for completing and returning the application materials before processing of my requested changes will continue.

Signature: _____ Date: _____