MUS_EB
Montana University System
Employee Benefits

2500 Broadway ◊ PO Box 203203 ◊ Helena, Montana 59620-3201 ◊ (406) 444-2574 ◊ FAX (406) 444-0222

MUS DEPENDENT PREMIUM WAIVER HARDSHIP APPLICATION

Please answer each question below. Partially completed applications will be returned.

Today's date _____
Policyholder's name _____Date of birth _____
Address _____ Campus where employed _____
_____ _____
_____
Contact telephone number _____ E-mail _____
ID# _____

Name, birthdate, and age of each dependent on policy

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Have you applied for coverage for dependent children age 0 to 19 through the Healthy Montana Kids Program (HMK)? YES _____ NO _____ If you applied and were denied coverage, please include a copy of the denial letter.

If your answer is NO, are the dependent children over 18, but less than 26? YES ___ NO ___
(Application to HMK is required for children 0 to 19, before a hardship can be considered)

What is your household size (total number of people living in your home)? _____

Do any family members have special needs, either medical or financial? YES ____ NO ____
If any, please briefly describe the needs: _____
_____

What is your total household income (before taxes)? _____

Please describe the hardship incurred, if any, that supports this application: _____
_____ _____

Policyholder's signature _____