CHOICES 2017-2018 COBRA Annual Enrollment Form
Montana University System Benefits Plan

Medical					**Total Monthly Costs**
Choose one plan **and** indicate the number of covered adults and/or children:	☐ Employee or Spouse or Individual Child(ren) (each) Monthly costs	☐ Employee + Spouse Monthly Cost[1]	☐ Employee + Child(ren)	☐ Employee + Family	
☐ Allegiance Plan	$813.00 Number ____	$1,192.00	$1,065.00	$1,443.00	
☐ Blue Cross Blue Shield Plan	$762.00 Number ____	$1,096.00	$1,013.00	$1,353.00	
☐ PacificSource Plan	$853.00 Number ____	$1,249.00	$1,117.00	$1,513.00	
Enter your monthly cost here	→				**$_________(A)**

Dental					
Choose one plan **and** one coverage level:	☐ Employee or Spouse or Child (each)	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family	
☐ Basic Plan	$18.00 Number ____	$35.00	$35.00	$49.00	
☐ Select Plan	$42.00 Number ____	$81.00	$81.00	$115.00	
Enter your monthly cost here	→				**$__________ (B)**

Vision		
☐ Yes ☐ No	☐ Employee or Spouse or Child (each) -------------- $8.20 ☐ Employee + Spouse ----------------------------------$15.48 ☐ Employee + Child(ren) -------------------------------$16.30 ☐ Employee + Family ---------------------------------- $23.92	**$__________ (C)**

Your Total Monthly Costs [Add up all your costs from right-hand column of this form (A) through (C)] → **$ ___________**

*The cost to continue COBRA coverage is up to 102% of the cost of coverage for similarly situated active employees and/or family members. The actual cost is not the same as the amounts used for **CHOICES** enrollment purposes.*

Check reason you are completing this form:	**Administrative Use Only**
☐ New COBRA Enrollment ☐ Annual COBRA Re-enrollment ☐ Other_______________________________________	**Campus Location:** ____ **Effective Date:** ____ **Insurance Class:** ____

MUS Employee Name:____ SSN: ____

[1] Children placed individually on the plan each pay the adult rate.

 IMPORTANT: COMPLETE BOTH SIDES OF THIS FORM

Personal

Birth Date: _______/_______/_________

COBRA Applicant Name: ____ SSN: ______________________________________

Address: ____ Qualifying Event Date: _______/_______/_____

City:_____________________ State: ____________________ ZIP: _________ Sex: ☐ Male ☐ Female

Telephone Number: ____ Marital Status: ☐ Married ☐ Single

If your spouse is still an eligible faculty or staff member, please provide his/her name, campus, and Social Security Number.

Spouse's Name: ____ SSN: ____

Campus: ____

List All Eligible Family Members Enrolled for Medical, Dental, or Vision Coverage

Name (Last, First, MI):	Birth Date (mm/dd/yyyy)	Enrolled in: Medical	Dental	Vision	SSN	Disabled	Check for Children Over Age 19:
Spouse	___/___/___	☐	☐	☐	_____________________	☐	
Dependent Child	___/___/___	☐	☐	☐	_____________________	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____________________	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____________________	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____________________	☐	☐
Dependent Child	___/___/___	☐	☐	☐	_____________________	☐	☐

Please attach list of additional family members.

I understand that any continued coverage elected on this form will terminate immediately upon the occurrence of one of the following events, regardless of whether premiums have been paid for coverage after such event: failure to pay the required premium on time; becoming covered under another group health plan not maintained by the Montana University System provided the individual does not have a preexisting condition which the new plan does not cover due to a plan exclusion or limitation; becoming entitled to Medicare; or termination by the Montana University System of all group health plans for all employees. I also understand that if extended coverage is provided due to Social Security disability, continued coverage will cease if the disabled individual is determined to have recovered. In such cases I will be entitled to a refund of any overpayment of premiums. I authorize the claims administrator or insurance company to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I declare that the information furnished on this form is true, correct and complete to the best of my knowledge. This form supersedes all previous forms I have submitted.

Employee's Signature: ____ **Date:**____

IMPORTANT: COMPLETE BOTH SIDES OF THIS FORM