



MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
Benefits Department

Montana University System – Employee Benefits

ADULT DEPENDENT DISSOLUTION FORM

Employee Name \_\_\_\_\_

Employing Campus \_\_\_\_\_ Employee SSAN # \_\_\_\_\_

This form must be attached to a MUS Choices Mid-Year Change Enrollment Form and is to be used to remove an enrolled Adult Dependent (and associated dependents of the Adult Dependent) from health care benefits coverage. Coverage ends at 11:59pm the last day of the month in which the Dissolution Form is signed below.

Adult Dependent's Name \_\_\_\_\_

Associated Dependent's Name(s) \_\_\_\_\_; \_\_\_\_\_;
\_\_\_\_\_;

Notification of Change in or Termination of Relationship

We, the undersigned, attest that our Adult Dependent relationship no longer exists.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Adult Dependent Signature \_\_\_\_\_ Date \_\_\_\_\_

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Note: Payments for coverage of Adult Dependents and associated dependents of the Adult Dependent will continue to be charged to the employee or retiree (or automatically deducted from the employee's paycheck) until the Adult Dependent Dissolution Form and MUS Choices Mid-Year Change Enrollment Form are received by your campus Human Resources office. Premiums paid pre-tax for a Dependent who is no longer eligible may not be retroactively adjusted to provide a refund back more than 30 days or beyond the start of the calendar year, whichever comes first.

\*\*Submit completed form to your campus Human Resources/Benefits office within 30 days of the date of dissolution. Failure to notify your campus Human Resources/Benefits office within 60 days of the date of dissolution results in the Adult Dependent's loss of COBRA rights as described in the Summary Plan Description.