MUS_EB
Montana University System
Employee Benefits

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DEPENDENT PREMIUM HARDSHIP WAIVER APPLICATION

Please answer each question below. Partially completed applications will be returned.		
Policyholder's Name:	Date of Birth:	
Mailing Address:		
City:	State:	Zip Code:
Contact telephone number:	E-mail:	
Health Plan ID#:		
Campus where employed:		
FAMILY INFORMATION		
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 enclose a copy of the denial letter.		
If your answer is NO, are the dependent children over age 18, but under age 26? ❑ YES ❑ NO (Application to HMK is required for children age 0 to 19, before a hardship application can be considered.)		
What is your household size (total number of people living in your home)?		
Name, birthdate, age, relationship of each person in the policyholder's household (add page if necessary):		
FINANCIAL INFORMATION		
Do any family members have special needs, either medical or financial? ❑ YES ❑ NO		
If any, please describe the needs (add page if necessary):		
What is your total household income (before taxes)?		
Please describe in detail the hardship incurred, if any, that supports this application (add page if necessary):		
Policyholder's signature: _____ Date: _____		