

**2018-2019 MONTANA UNIVERSITY SYSTEM CHOICES RETIREE SURVIVOR ENROLLMENT FORM**

**INSTRUCTIONS & DEADLINE FOR ENROLLMENT** – Use this form to elect the Montana University System Benefit Plan benefits as a surviving spouse and/or dependent(s) of a Retiree of the Montana University System.

The covered surviving legal spouse or child(ren) (under the age of 26) of an MUS Retiree may remain a Covered Person of the Montana University System Benefit Plan and continue their current medical, dental, and/or vision hardware coverage as long as the required self-payment of premiums is made.

**This form must be returned to the applicable campus mailing address on the back of this form within 63 days of the MUS Retiree’s date of death.**

**Surviving Dependent(s) Information**

Name: \_\_\_\_\_  
 \_\_\_\_\_  
 Last First MI Date of Birth Social Security Number  
 \_\_\_\_\_  
 Is this a new address?  Yes  No  
 \_\_\_\_\_  
 Mailing Address City State Zip  
 Phone (Home): \_\_\_\_\_ Phone (Other): \_\_\_\_\_  
 Email Address: \_\_\_\_\_ HICN # (Medicare ID #): \_\_\_\_\_

**Qualifying Event**

- Waiver of Coverage** - I have been given the opportunity to enroll in the MUS Benefits Plan as a Survivor and decline all participation.
- Survivor(s) Enrollment**
- Annual Enrollment**

**Campus (circle):** OCHE MSU MSU-B MSU-N GFC-MSU UM MT Tech UM-W HC-UM FVCC MCC DCC State Bar

**Medical Coverage**

**Coverage Level (choose one)**  
 Decline Coverage  
 Survivor  
 Survivor + Child(ren)  
 \* (mp) = Medicare Primary - Retirees (generally 65 and older)  
 \* Medicare = Participants must be enrolled in Parts A & B - IT IS REQUIRED!  
 Enter your monthly Medical Plan cost here (see *Choices* Enrollment Workbook). **Medical Premium:** \$ \_\_\_\_\_

- Medical Plan (choose one)**  
 Allegiance  
 BlueCross BlueShield  
 PacificSource

**Dental Coverage**

**Coverage Level (choose one)**  Decline Coverage  
 Survivor Only - \$52/month  
 Survivor + Child(ren) - \$94/month  
**Dental Premium:** \$ \_\_\_\_\_

**Optional Vision Hardware Coverage**

**Coverage Level (choose one)**  Decline Coverage  
 Survivor Only - \$9.71/month  
 Survivor + Child(ren) - \$19.30/month  
**Vision Premium:** \$ \_\_\_\_\_  
**Total Monthly Premium:** \$ \_\_\_\_\_

**Dependent Coverage**

|            |       |       |    |               |       |        | Keep                     | Remove                   |
|------------|-------|-------|----|---------------|-------|--------|--------------------------|--------------------------|
|            | Last  | First | MI | Date of Birth | SSN # | HICN # | <input type="checkbox"/> | <input type="checkbox"/> |
| Survivor:  | _____ |       |    |               |       |        | <input type="checkbox"/> | <input type="checkbox"/> |
| Dependent: | _____ |       |    |               |       |        | <input type="checkbox"/> | <input type="checkbox"/> |
| Dependent: | _____ |       |    |               |       |        | <input type="checkbox"/> | <input type="checkbox"/> |

Attach a list if you have additional covered dependents.

My signature indicates that I have read and understand the election form and materials describing options provided by MUS *Choices*, including information contained in the MUS *Choices* Benefits Enrollment Workbook. My election or waiver of coverage is binding and cannot be revoked or modified. I authorize my benefit plan to obtain, examine, or release information as 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.

Survivor Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAILING ADDRESSES AND ADDITIONAL INFORMATION ARE ON THE BACK SIDE OF THIS FORM.**

## 2018-2019 MONTANA UNIVERSITY SYSTEM *CHOICES* RETIREE SURVIVOR ENROLLMENT

**Eligibility:** A covered surviving dependent of a Retiree of the Montana University System (MUS), including the Office of the Commissioner of Higher Education or other agency or organization affiliated with MUS or the Board of Regents of Higher Education, may continue MUS group insurance benefits as described below.

**Continuation of Coverage:** Covered surviving dependent(s) of an MUS Retiree must make arrangements with his/her campus Human Resources/Benefits Office to continue coverage as a survivor on a self-pay basis within 63 days of the MUS Retiree's death. **There is no Employer contribution toward survivor benefits.** The right to continue coverage under the Plan is a one-time opportunity. **Survivors who fail to continue coverage within 63 days of death of the MUS Retiree or who allow coverage to lapse due to nonpayment of premiums may not later rejoin the Plan.** No new dependents can be added to the survivor's coverage, with the exception of a child born to the surviving legal spouse that was conceived before or a child for whom adoption proceedings were initiated before the MUS Retiree's death, may also be enrolled in the Plan, provided the child is enrolled within sixty-three (63) days of birth or adoption.

### Available Coverages

**Medical Coverage:** Enrollment in a Medical Plan is available to covered surviving dependents. Coverage is permanently forfeited if the covered surviving dependent(s) cancels medical coverage, or fails to pay premiums.

**Dental Coverage:** Enrollment in the Select Dental Plan (only) is available to covered surviving dependents. Coverage is permanently forfeited if the covered surviving dependent(s) cancels dental coverage, or fails to pay premiums.

**Vision Hardware Coverage:** The Vision Plan is for vision hardware only. Eye exams, whether preventive or medical, are covered under the Medical Benefit Plan. Coverage is permanently forfeited if the covered surviving dependent(s) cancels vision coverage, or fails to pay premiums.

**Long Term Care Insurance:** If the deceased Retiree was enrolled in Long-Term Care Insurance through UNUM, contact your campus Human Resources/Benefits Office for conversion information.

### Please Send Your Form to the Appropriate Address Below

|   |              |
|---|--------------|
| MSU-Bozeman Human Resources, PO Box 172520, Bozeman, MT 59717                         | 406-994-3651 |
| MSU-Billings Human Resources, 1500 University Dr., Billings, MT 59101                 | 406-657-2278 |
| MSU-Northern Human Resources, 300 West 11th Street, Havre, MT 59501-7751              | 406-265-4147 |
| Great Falls College-MSU Human Resources, 2100 16th Ave. S., Great Falls, MT 59405     | 406-268-3701 |
| UM-Missoula Human Resources, 32 Campus Dr., Lommasson 252, Missoula, MT 59812         | 406-243-6766 |
| Helena College-UM Human Resources, 1115 N. Roberts, Helena, MT 59601                  | 406-447-6925 |
| UM-Western Human Resources, 710 S. Atlantic St., Dillon, MT 59725                     | 406-683-7010 |
| MT Tech (UM) Human Resources, 1300 W. Park St., Butte, MT 59701                       | 406-496-4380 |
| OCHE, MUS Benefits Office, PO Box 203203, Helena, MT 59620-3203                       | 877-501-1722 |
| Dawson Community College Human Resources, 300 College Dr., Glendive, MT 59330         | 406-377-9401 |
| Flathead Valley Comm. College Human Resources, 777 Grandview Dr., Kalispell, MT 59901 | 406-756-3981 |
| Miles Community College Human Resources, 2715 Dickinson St., Miles City, MT 59301     | 406-874-6292 |
| State Bar of MT, PO Box 577, Helena, MT 59624-0577                                    | 406-442-7660 |

\*Call your campus Human Resources/Benefits Office or MUS Benefits Office at 877-501-1722, if you have questions about your benefits enrollment form.\*