MUS_EB
Montana University System
Employee Benefits

2018/2019 *Choices* Enrollment Form

Name:

☐ **WAIVER OF COVERAGE**

Effective Date of Coverage:

I have been given the opportunity to enroll in the MUS Benefits Plan and decline at this time. ** Sign and date page 3

*** Indicates Mandatory Benefits Enrollment**

Medical * *Choose a plan & coverage level*	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	**Monthly Cost**
Allegiance	$798.00	$1,169.00	$1,045.00	$1,415.00	
Blue Cross Blue Shield	$748.00	$1,075.00	$994.00	$1,327.00	
Pacific Source	$837.00	$1,225.00	$1,096.00	$1,484.00	
Enter your Cost here					*(A)
Dental * *Choose a plan & coverage level*	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
Select Plan	$42.00	$80.00	$80.00	$113.00	
Basic Plan	$18.00	$35.00	$35.00	$49.00	
Enter your Cost here					*(B)
Life Insurance/Accidental Death & Dismemberment *					
Choose one:	$15,000	$1.49			
	$30,000	$2.97			
	$48,000	$4.75			
Enter your Cost here					*(C)
Long Term Disability *					
Choose one: 60% of pay/6-month wait		$5.90			
66-2/3% of pay/6-month wait		$11.75			
66-2/3% of pay/4-month wait		$14.66			
Enter your Cost here					*(D)
Optional Vision	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
Vision Hardware	$9.71	$18.34	$19.30	$28.31	
Enter your Cost here					(E)
Cost ..... **Total Lines A-E**					(F)
Total Monthly Employer Contribution					**-1054 (G)**
Total Monthly before-tax insurance costs ..... **Lines G minus F**					(H)

Flexible Spending Accounts	
Note: NO employer contribution can be used towards a Flexible Spending Account	**Flex Spending**
You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!)	**Yes☐ No☐**
There are NO exceptions for late enrollment or late submissions	
Mid-Year Change for Medical Flexible Spending must be consistent with event	
Medical Annual Amount: Minimum of $120 Maximum $2,650/Employee	
If your spouse has a Health Saving Account (HSA) you may have a limited purpose flex for dental and vision only	
Please make your election and contact Allegiance to have it setup as a limited purpose account only	
Salary Reduction for Medical Flex Monthly Amount	
Dependent Care Annual Amount: Minimum $120 Maximum $5,000/Employee	
Dependent Flex Monthly Amount	
Adoption Assistance Annual Amount: Minimum $120 Maximum $13,570 (Total max-NOT annual max)	
Adoption Assistance Flex Monthly Amount	
Total Monthly Election	

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Enrollment Continued After Tax Benefits

Name: _____

Please refer to the *Choices* enrollment workbook for premium amounts.

Optional Employee Supplemental Life Insurance

Monthly Cost

Employee's coverage may increase one level at annual enrollment without evidence of good health.
Coverage over $300,000 always requires evidence of good health.

Amount	Amount	Amount	Amount
☐ $25,000.00	☐ $50,000.00	☐ $75,000.00	☐ $100,000.00
☐ $125,000.00	☐ $150,000.00	☐ $175,000.00	☐ $200,000.00
☐ $225,000.00	☐ $250,000.00	☐ $275,000.00	☐ $300,000.00
☐ $325,000.00	☐ $350,000.00	☐ $375,000.00	☐ $400,000.00
☐ $425,000.00	☐ $450,000.00	☐ $475,000.00	☐ $500,000.00
☐ $525,000.00	☐ $550,000.00	☐ $575,000.00	☐ $600,000.00

Enter your Cost here ..... (I)

Optional Spouse Supplemental Life Insurance

Employee must be enrolled in Supplemental Life Insurance in order to select spousal coverage.
Spousal elected life insurance cannot exceed 50% of the employee election.
Spousal coverage over $50,000 always requires evidence of good health.
Employee must be the beneficiary for spousal life insurance coverage.
Spousal coverage may increase one level at annual enrollment with evidence of good health.
New Hires may elect any amount for spousal covereg keeping in mind the rules above.

Amount	Amount	Amount	Amount
☐ $25,000.00	☐ $50,000.00	☐ $75,000.00	☐ $100,000.00
☐ $125,000.00	☐ $150,000.00	☐ $175,000.00	☐ $200,000.00
☐ $225,000.00	☐ $250,000.00	☐ $275,000.00	☐ $300,000.00

Enter you Cost here ..... (J)

Optional Child Supplemental Life Insurance

Employee must be enrolled in Supplemental Life Insurance in order to select child coverage.
Employee must be the beneficiary for Child life insurance coverage.
Child coverage may increase one level at annual enrollment without evidence of good health.

Amount	Amount	Amount	Amount
☐ $5,000.00	☐ $10,000.00	☐ $15,000.00	
☐ $20,000.00	☐ $25,000.00	☐ $30,000.00	

Enter your Cost here ..... (K)

Optional Supplemental Accidental Death & Dismemberment Insurance

Employees may elect any coverage amount at annual enrollment.
Employees must elect AD&D coverage on themself if electing coverage on dependents.

Amount	Amount	Amount	Amount
☐ $25,000.00	☐ $50,000.00	☐ $75,000.00	☐ $100,000.00
☐ $125,000.00	☐ $150,000.00	☐ $175,000.00	☐ $200,000.00
☐ $225,000.00	☐ $250,000.00	☐ $275,000.00	☐ $300,000.00
☐ $325,000.00	☐ $350,000.00	☐ $375,000.00	☐ $400,000.00
☐ $425,000.00	☐ $450,000.00	☐ $475,000.00	☐ $500,000.00
☐ $525,000.00	☐ $550,000.00	☐ $575,000.00	☐ $600,000.00

Enter your Cost here ..... (L)

Optional Spouse Accidental Death & Dismemberment Insurance

Employee must be enrolled in AD&D in order to select spousal coverage.
Spousal coverage may increase to any level at annual enrollment.

Amount	Amount	Amount	Amount
☐ $25,000.00	☐ $50,000.00	☐ $75,000.00	☐ $100,000.00
☐ $125,000.00	☐ $150,000.00	☐ $175,000.00	☐ $200,000.00
☐ $225,000.00	☐ $250,000.00	☐ $275,000.00	☐ $300,000.00

Enter your Cost here ..... (M)

Optional Child(ren) Accidental Death & Dismemberment Insurance

Employee must be enrolled in AD&D in order to select child coverage.
Child coverage may may increase to any level at annual enrollment.

Amount	Amount	Amount
☐ $5,000.00	☐ $10,000.00	☐ $15,000.00
☐ $20,000.00	☐ $25,000.00	☐ $30,000.00

Enter your Cost here ..... (N)

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Check the reason you are completing this form:

☐ New Enrollment* ☐ Annual Enrollment ☐ Annual Enrollment Default to same coverage**

Employee Information

Name (Last,First, MI): Social Security Number:

Address: City, State, Zip:

Phone: Home: ( ) Birth Date:

Work: ( ) HICN # (Medicare Assigned) :

Gender: ☐ Male ☐ Female Date of Hire: _____

Enrollment Status: ☐ Married ☐ Single Email: _____

Below List All Eligible Family Members Enrolled For Medical, Dental, Vision Hardware, Optional Supplemental Life, and/or Optional AD&D

Name (Last, First, MI)	Birth Date (Mo/Day/Year)	Gender M	Gender F	Enrolled In: Med.	Den.	Vis.	Basic Life	Opt. Supp. Life	Opt. AD&D	Disabled Child	MANDATORY! Social Security #	Medicare HICN #
Employee												
Spouse												
Dependent												
Dependent												
Dependent												
Dependent												

If you run out of spaces for additional family members, please attach a list to this form.

By enrolling dependents, you verify that the dependent(s) meets dependent eligibility requirements and that proof to establish the dependents relationship to you may be required.

List Your Beneficiaries For Employee Life and/or AD&D Insurance Beneficiaries

Primary (Last, First, MI) Relationship:

Contingent (Last, First, MI) Relationship:

If more than one Primary or Contingent beneficiary is to be specified, attach beneficiary information on a separate page. Unless otherwise specified, payment will be shared equally by all primary beneficiaries who survive the Insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiaries is reserved unless otherwise stated.

My Signature indicates that I have read and understand the election form and materials describing options provided by *Choices* , including information contained in the notices section of the *Choices* Enrollment Workbook. My election or waiver of coverages is binding and cannot be revoked or modified (other than as explained in the materials). I understand that my salary will be reduced by the amount designated and that the arrangement for paying premiums with before-tax dollars is intended to meet IRS requirements. If tax laws change or if this arrangement is deemed not to satisfy IRS requirements, I understand that the tax advantage described may not be available.

I authorize the MUS Plan, and its contracted Business Associates to obtain, examine or release information needed to coordinate benefits, manage my care, 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. If I waived coverage, I understand that satisfactory evidence of insurability may be required to enroll in Life and Long Term Disability and Long Term Care insurance at a later date.

Employee's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Dependent Over 18 Signature: _____ Date: _____