2019-2020 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/MBI # (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)

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

* (mp) = Medicare Primary - Retirees (generally 65 and older)

* Enrollment continuation is a one time opportunity, see back-side for details

* 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:** $ ______________

Dental Coverage

Coverage Level (choose one)
☐ Decline Coverage
☐ Survivor Only - $52/month
☐ Survivor + Child(ren) - $94/month

* Enrollment continuation is a one time opportunity, see back-side for details

Dental Premium: $ ______________

Vision Hardware Coverage

Coverage Level (choose one)
☐ Decline Coverage
☐ Survivor Only - $10.70/month
☐ Survivor + Child(ren) - $21.26/month

Vision Premium: $ ______________

Total Monthly Premium: $ ______________

* Enrollment continuation is a one time opportunity, see back-side for details

Dependent Coverage

	Last	First	MI	Date of Birth	SSN #	HICN/MBI #	Keep	Remove
Survivor:							☐	☐
Dependent:							☐	☐
Dependent:							☐	☐

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.