MUS_EB
Montana University System
Employee Benefits

2013/2014 *Choices* Enrollment Form

Name:

SS#:

☐ **WAIVER OF COVERAGE**

I have been given the opportunity to enroll in 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**
Traditional Plan	$688.00	$960.00	$933.00	$1,231.00	
Allegiance Managed Care	$613.00	$855.00	$831.00	$1,097.00	
Blue Cross Blue Shield Managed Care	$576.00	$804.00	$781.00	$1,031.00	
Pacific Source Managed Care	$592.00	$826.00	$803.00	$1,060.00	
Enter your Cost here ……					*(A)
Dental * *Choose a plan & coverage level*	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
Premium Plan	$42.00	$80.00	$80.00	$113.00	
Basic Plan	$16.00	$31.00	$31.00	$43.00	
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)
Vision	**Employee**	**Emp + Sp**	**Emp + Child(ren)**	**Emp+ Family**	
EyeMed Vision	$7.11	$13.42	$14.13	$20.73	
Enter your Cost here ……					(E)
Cost …… Total Lines A-E					(F)
Total Monthly Employer Contribution ……					**-806 (G)**
Total Monthly before-tax insurance costs …… Lines G minus F					(H)

Positive amount is amount of salary reduction. Negative amount can be applied to Medical Flexible Spending Acct.

(Note: Any negative amount not spent on the Medical Flexible Spending Acct. will be forfeited)

Flex Spending
Yes ☐ No ☐

You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!)

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 $2,500/Employee

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 $12,650 (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.

Please note that you may elect either Supplemental Life of Supplemental Life + AD&D but not both.

Optional Employee Supplemental Life Insurance

Monthly Cost

Employee's coverage may bump up 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 you 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 bump up one level at annual enrollment without 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

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 bump up one level at annual enrollment without evidence of good health.

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

Enter you Cost here …… (K)

Optional Employee Supplemental Life + AD&D Insurance

Employees coverage may bump up 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 you Cost here …… (L)

Optional Spouse Supplemental Life + AD&D 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 bump up one level at annual enrollment without 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

Enter you Cost here …… (M)

Optional Child Supplemental Life + AD&D 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 bump up one level at annual enrollment without evidence of good health.

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

Enter you 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** ☐ Mid-Year Change

**(If you had other coverage within last 63 days, provide Certificate of Creditable Coverage.) **(No default for Reimbursement Accounts.)*

Employee Information

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

Address: City, State, Zip:

Phone: Home: ( ) Birth Date:

Work: ( ) **Enrollment Status:**

Gender: ☐ Male ☐ Married ☐ Single

☐ Female ☐ Claiming an Adult Dependent

(Attach Declaration of Adult Dependent Form)

Below List All Eligible Family Members Enrolled For Medical, Dental, Vision, Optional Supplemental Life, Optional Supplemental Life + AD&D

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

Information About Other Group Coverage

Are you, your spouse or any dependents continuing coverage with another plan? (Please include anyone eligible or covered by Medicare/Medicaid.)

☐ YES ☐ NO If yes complete below:

Name (Last,First,MI):	Medical	Dental	Other Employer	Name and Number of Plan
Employee	☐	☐		
Spouse/ Adult Dependent	☐	☐		
Dependents	☐	☐		

List Your Beneficiaries For Employee Life or Life + 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. If you are married, but choose someone other than your spouse as beneficiary, have your spouse sign below to acknowledge the other beneficiary.

Spouse's Signature: Date:

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 (or I will forfeit any remaining Employer Contribution) 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: